

The realization of a special cohort unit in the prevention of a general outbreak of SARS CoV2 in Flemish nursing homes.

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INTRODUCTION

In Belgium, very soon after the onset of the pandemic and before the start of a general lockdown, a ban was put on family visits to residents of nursing homes. Federal recommendations mentioned quarantine of SARS CoV2-positive residents on designated cohort units within residential care facilities. However, the Flemish Agency for Care approved the initiative of a group of residential care facilities to install a centralized special cohort unit for older adults with COVID-19.

SARS CoV2 infected residents from 6 residential care facilities (consortium with 580 residents) were transferred to this unit, as well as SARS CoV2 infected elderly adults who were discharged from hospital but who were too frail to return home. A close collaboration in a model of shared clinical care was set up with an 810-bed regional hospital and coordinating physician of the primary care zone. The unit provided care for 10 residents, with the possibility to scale up with 10 additional places on standby.

The **AIM** of shared clinical care in the management of SARS CoV2 was:

1. to protect the health status of residents and caregivers in nursing homes
2. to provide optimal and more specialized care to COVID-positive residents
3. to guarantee the continuity of standard care in hospitals and residential facilities
4. to reduce stress and anxiety among caregivers and residents

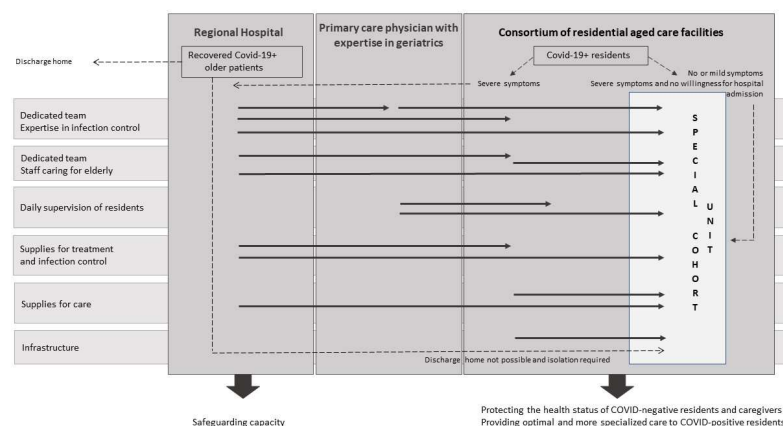


Figure 1: Model for shared clinical care. Gillis K, et al. (2020). A model for shared clinical care in the COVID-19 crisis. *Infection Control & Hospital Epidemiology*, <https://doi.org/10.1017/ice.2020.363>

METHOD

Due to the format of **shared clinical care** between the regional hospital, the consortium and the primary care zone, the conditions assumed to make such unit possible were achieved.



Figure 2: Photo of the special cohort unit

RESULTS

Health status of residents and caregivers: The hospital outsourced an infection prevention physician to share insights, protocols and procedures on infection prevention. Over 52 days, 15 residents were admitted to the special cohort unit. Among them, 13 residents of the consortium and 2 individuals were admitted because they could not return home after discharge from the hospital. Six patients died. Prevention of further outbreak was realized in 5 of 6 residential facilities of the consortium. After 30 days, all members of the nursing team tested negative for COVID-19.

Optimal and more specialized care: Nurses and nurse-assistants (9 FTE) were selected on voluntary base. The level of experience and education was above the average in regular units in Flemish residential facilities. The voluntary character and the level of education enabled nurses to work autonomously in this cohort unit. However supplies for more invasive therapy, like IV therapy, were provided and the level of education and staffing of nurses was similar as in a hospital setting, the given therapy and care was typical for a residential care setting. The primary care physician and the nurses learned about the pathophysiology and therapy of COVID-19 by experience, more formal education and simulation training is recommended.

Continuity of standard care: Vacancies in the residential care facilities created due to the absence of permanent staff for the special cohort unit were filled by nurses from the hospital. While this was possible during the first COVID-19 wave, another sustainable solution to ensure continuity of care in the residential facilities is needed. The capacity of the hospital was safeguarded.

Reduction of stress and anxiety: The realization of a special cohort unit reduced stress and anxiety among other residents and caregivers. Psychological support was available for the special cohort team. They felt out of connection with their mother-team and were afraid of the work-related consequences of being COVID-19 positive. After a few weeks their level of exhaustion increased, without having perspective of the possibility to leave the special cohort unit. A well-designed HR-management for the members of a special cohort team can decrease the level of exhaustion.

CONCLUSION

The realization of a special cohort unit, based on the principles of shared clinical care, can prevent further outbreak of SARS CoV2 in nursing homes and other residential care facilities. More formal education and a well-designed HR-management for the caregivers of the special cohort unit is recommended, as well as a sustainable solution for continuity of care in the non-special cohort units.